Patient Education In Primary Care:

KEY TO ACTIVE VETERAN PARTICIPATION

Volume III Issue 2 **October 1999**
Published by the Office of Primary & Ambulatory Care and the VA Learning University Patient Education Program

WELCOME to our new resource for patient education and primary care![1]

- **WHAT IS IT?** The purpose of this tool is to provide a mechanism to help meet the challenges of incorporating effective patient teaching into primary health care.
- **WHO IS IT FOR?** VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decisionmakers

THE SUMMER OF 1999: WHAT WERE JCAHO SURVEYORS LOOKING FOR?

While the actual content of a JCAHO survey depends on the specific surveyor team as well as the size and characteristics of the institution, reviewing results of others' experiences can be helpful in planning for upcoming visits. Five VA medical centers in VISN 18 whose surveys were conducted during June - July 1999 provide feedback about their recent visits.. Although the actual survey process varied from focussed interviews with patient education teams to integrated approaches throughout a facility, a number of common and recurring themes emerged from the various sites. All sites received scores over 90.

Patient education should be interdisciplinary rather than just multidisciplinary. Surveyors continue to distinguish between multidisciplinary and interdisciplinary care of the patient. Are providers talking to each other to plan an integrated approach to patient care? Are team members working together rather than "by discipline" in arriving at a treatment plan? Does charting and documentation of patient education reflect an integrated approach among team members or is it repetitious and reflective of many disciplines charting and filling out forms to create a voluminous record without continuity?

Clinical examples demonstrating that patient education is not only interdisciplinary but represents the continuum of care are important. For example, when a patient is scheduled for a total hip replacement, when does patient education begin and who initiates it? How is it tracked across the continuum of care from the time surgery is scheduled through discharge and follow-up as an outpatient? Special attention was directed at patients returning to rural areas in terms of providing consistency and continuity in patient education. Having several providers con-

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[1]**This publication may be duplicated. It is also available on the VA website at http://www.va.gov/visns/visn02/emp/education/education.html.**

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tribute to this discussion is very helpful, especially if they can reflect a case management approach.

An educational assessment of the patient that includes cultural and religious beliefs is more than a form. Providers must go beyond a well-designed form and talk with patients to truly determine their cultural/religious preferences and beliefs. Once the patient has been assessed, there must be evidence that steps are being taken to accommodate any special needs or beliefs. Can you give examples of how your institution is ready to meet the special needs of your population? Some examples that were well received by surveyors include the availability of print materials designed by Native Americans for that population, local recipes commonly used by Hispanics that are low fat and heart healthy, a list of language interpreters (which may include staff) and a number to call for uncommon languages.

Evidence that alternative therapies and medicines are considered in the care of the patient. How do providers assess this and is it done routinely in the primary care setting? What information is available to patients? How is this patient assessment communicated across disciplines? Can you provide examples of how this need is met at your institution? Actual handout materials and provider narratives of the assessment process were well received.

In those settings where patient education was not a focussed interview but integrated throughout the survey, a significant patient education emphasis was reported in nutrition and pharmacy surveys. Food/drug interactions, medication instruction and assessment of the patients were given considerable attention. Surveyors routinely asked how and when

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EDUCATION IS THE KEY!

TALK WITH YOUR DOCTOR
LEARN TO PREPARE A LIST
TELL YOUR DOCTOR:

- ✔ Your problem, report any unusual symptoms
- ✔ History with problem
- ✔ Your medications
- ✔ Lifestyle changes

ASK QUESTIONS / ASK QUESTIONS

- ✔ Know your diagnosis
- ✔ Inquire about tests
- ✔ What are your treatment options

FOLLOW-UP:

- ✔ Know your next appointment
- ✔ What should you watch for?
- ✔ What should you report to your doctor?
- ✔ Know future tests and preparation for tests

Call TELICARE with questions about your treatment/medication

LOCAL: 776-6193
LONG DISTANCE: 1-877-225-8262 (Toll Free)
Northern Arizona VA Health Care System

(Figure 1)

PLAN FOR NOVEMBER 1999 HEALTH OBSERVANCES

(Materials available from sponsoring organizations)

Alzheimer's Awareness Month
800/272-3900

Diabetes Month
800/232-3472

Epilepsy Month
301/EFA-1000

Great American Smokeout (11/18)
800/ACS-2345

World AIDS Day (12/1)
202/466-5883

For a complete list of national health observances by month and contact information go to the National Health Information Center's web site at <http://nhic-nt.health.org/pubs/> or call to order a single copy of the associated publication at 800/336-4797.

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these areas were addressed at the facility, who had responsibility and where they were documented.

How to Get Ready

VISN 18 staff also shared a number of creative tools developed to educate staff and patients prior to the survey. They were also, however, incorporated into the survey visit itself. For example,

- One of the things the surveyors liked at the Northern Arizona VA Health Care System (formerly Prescott) was a framed suggested question list for patients located in each waiting area (Figure 1). Staff at this medical center also use the mail to reach veterans with patient education messages. Condensed flyers with information on health education classes and lectures on health topics of interest are mailed with appointment card reminders.

- If you have a patient on your Patient Education Team, consider inviting the individual to participate in the JCAHO interview. Be sure to prepare the individual ahead of time so that he/she is comfortable describing his/her role on the team. This is a powerful strategy that reflects consumer involvement and community representation. The enthusiasm and excitement that can be generated naturally is very positive for the interview process.

- If you have a learning center or centralize your patient health information in primary care, consider using this as an opportunity to walk the surveyor through as you would a patient, to experience the assessment process (of identifying special learning needs) and seeing how those needs are met in an interdisciplinary fashion. Directing attention to the things you already do well will have a bigger pay-off than trying to create new things at the last minute for the sake of a survey. At the Albuquerque facility, the Patient Education Interview was experiential and staged in the Learning Center, using regular veteran team members to showcase their role and the interdisciplinary scope of each visit to the center.

- Publishing a booklet for staff education prior to JCAHO is an effective strategy to orient staff to patient education standards and also provides a pocket reference as they prepare for JCAHO in their respective roles. A "Patient/Family Education Guidebook for Employees " was developed at the El Paso VA Health Care System with an index that references clinical disciplines, actual curriculums in use, teaching tips, policies, and so forth. A credit sheet lists contributions from the disciplines involved. Presented to surveyors early in the survey, the guidebook was seen as evidence of interdisciplinary involvement in patient education because it encourages staff to use others as resources.

Special thanks to Carol Maller, MS, RN, CHES, Patient Health Education Coordinator, Albuquerque VAMC, NM for gathering and organizing the information for this review; FTS 700/572-4656; COM 505/265-1711, Ext. 4656.
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HOW DO WE KNOW PATIENT EDUCATION WORKS?

STROKE

Members of the National Stroke Association's (NSA's) Stroke Prevention Advisory Board and Cedars-Sinai Health System Department of Health Services Research convened to establish, in a single resource, up-to-date recommendations for primary care providers regarding prevention strategies for a first stroke. Six clinical risk factors (hypertension, myocardial infarction, atrial fibrillation, diabetes mellitus, blood lipids, asymptomatic carotid artery stenosis) and 4 lifestyle factors (cigarette smoking, alcohol use, physical activity, and diet) for a first stroke were identified. This article reviews research documenting what is known about effective interventions to modify these risk factors. Measures to help patients improve adherence to their treatment regiments also contribute to a stroke prevention plan.

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Gorelick, PB et al. (1999) Prevention of a first stroke: a review of guidelines and a multidisciplinary statement from the National Stroke Association. JAMA. 281(12):1112-1120.

MEDICATION ADHERENCE

This study tested the validity of the Brief Medication Questionnaire (BMQ), a new self-report tool for screening adherence and barriers to adherence. The tool includes a 5-item Regimen Screen that asks patients how they took each medication in the past week, a 2-item Belief Screen that asks about drug effects and bothersome features, and a 2-item Recall Screen that asks about potential difficulties remembering. Validity was assessed using the medication Events Monitoring System which involves dispensing each patient's medication in a bottle that contains a microprocessor chip in the cap. Results varied by type of non-adherence with the Regimen and Belief Screens having 80-100% sensitivity for "repeat" non adherence and the Recall Screen having 90% sensitivity for "sporadic" non-adherence. This screening tool appears more sensitive than existing tools and may be useful in identifying different types of adherence problems.

Svarstad, BL, Chewning, BA, Sleath, BL, and Claesson, C. (1999) The brief medication questionnaire: a tool for screening patient adherence and barriers to adherence. Patient Education and Counseling. 37: 113-124.

PATIENT EDUCATION/PRIMARY CARE PROGRAM NOTES

Exit Interviews: To Do or Not to Do

A major challenge for busy primary care managers is how to make sure that patients understand their care plans when they leave the clinic. Exit interviews—usually with a nurse to review new treatment plans and assure that important patient questions have been answered—are being tried by many VA facilities. Although staff report a growing acceptance of the importance of these visits and evidence that they result in increased veteran knowledge about the health care system, more consistent preparation for diagnostic tests and more complete chronic disease and prevention screenings, there are also challenges. Adding time at the end of a visit can slow down patient flow, annoying veterans and providers alike. Limited examining room space and access to computers, staff absences, and walk-in clients also restrict a clinic's ability to consistently implement these interviews.

As VAMCs gain experience with different models of primary care, making adjustments to better meet the unique needs of veterans, outpatient managers are evolving different approaches to exit interviews. For example, in Temple TX, where the primary care team structure includes 2 RNS and 2 LPNs for six providers (MDs, PA, NP), the physicians have assumed responsibility for identifying the 50% or so of patients who need additional time with the nurse (usually the RN) at the end of the visit. Although everyone does not receive an exit interview, Mary Schwanke, Case Manager, Primary Care believes that most needy patients are seen and this approach is feasible given time and staffing constraints. Nursing also screens patients as they are doing vital signs during the intake process. For example, if an LPN finds out that a diabetic had two candy bars for dinner, she might ask the RN to talk with the patient before the physician visit or specially ask the physician to refer the patient after the medical interview. Access to an exit interview documentation template (See January 1999 issue of Patient Education in Primary Care) as part of the Computerized Patient Record System (CPRS) enhances the nurse's ability to review referrals, diagnostic test preparation, and other teaching requirements as part of the interview.

In Brooklyn NY the nursing staff initially focused on entry interviews, catching every patient that came through the clinic with vital signs and a quick triage. Gradually over time, however, the physicians have begun to actively support the provision of exit interviews to assure coordination of care and completion of the prevention requirements. The Associate Chief of Medicine, a long time member of the primary care/quality improvement team, has backed the concept of exit interviews and the primary care physicians and nurses have worked together to develop a complementary teaching process. For example, the physicians agreed to address the CAGE screen and the depression screen while nursing focused on smoking assessments, review of immunizations and referrals. Not only do the physicians now tell nearly every patient to see the nurse, but the clerks often ask if the patient has seen the RN.

However, given that up to 40% of patients do not receive an exit interview, Rose Browne, nurse manager at Brooklyn, sees implementation as an ongoing challenge. Separating the documentation record into three sections has streamlined the process because it allows different nursing personnel to begin the exit interview as they are available.

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Part 1, which can be done by the nursing assistant, the LPN or the RN, includes review of assigned laboratory tests, provision of written instructions and verifying the patient's return to clinic. Part 2 to be completed by the LPN or RN includes an opportunity to discuss the priority prevention categories including cholesterol, physical activity and nutrition, specific self-management behaviors such as blood pressure monitoring and inhaler use, and referrals to classes, pharmacy or dietary. Finally Part 3 is an overall assessment by the RN of the patient's ability to carry out the prescribed treatment plan.

At the time exit interviews were established at the Battle Creek, MI VAMC, the associate Chief of Staff for Ambulatory Care worked with Nursing Service to develop a clear standard—all outpatients were to be seen by a nurse prior to leaving the clinic. Estimating that nearly 90% of patients actually receive an interview, outpatient unit manager Helen Parkis emphasizes that RNs carry the process from intake through exit. The RN assigned to the patient's physician begins the visit by checking vital signs and reviewing the patient's goals at the last visit. For example, if the patient is trying to control blood pressure, then the nurse might review records that the patient has kept between appointments and document results. After the physician has seen the patient the nurse returns to review the treatment plan, refer to others such as the pharmacist or dietitian for specialized teaching, and identify any new patient goals **(See Figure 2 on page 6 for example of Battle Creek's computerized exit interview template)**. Most recent quality improvement monitoring results show that for those patients receiving exit interviews 97% had documentation of patient goals and 86% of progress toward patient goals.

In spite of Battle Creek's success in implementing exit interviews, nursing staff report continuing challenges. For example, while increasing ease of data retrieval the implementation of CPRS has, at least in the short run, slowed patient flow and reduced the ability of nurses to reach every patient with an exit interview. First, the exit interview form had to be broken into two parts—intake and exit thus requiring the nurse to enter the patient's record twice. Once the intake portion is complete (vital signs and assessment of previous patient goals), the nurse must sign the note so it can be released and read by the physician. Second, because of limited examining rooms and accessibility to computers, and lack of dedicated workspace for nursing staff, it is very difficult for nursing to keep up with computerized documentation. For example, staff turned the annual wellness form into a patient friendly handout and checklist; however, while the patient response was good, the nurses now have a back log of data which has to be entered into CPRS as time and computers are available. This last problem will hopefully be solved soon as the wellness review will be pulled out of the exit interview and implemented separately on an annual basis.

Some medical centers have chosen strategies other than exit interviews to meet ongoing outpatient education needs. For example, at the Salt Lake City VAMC, a nursing case management program is the backbone of patient teaching. Providers are assigned to each of six RN s who are then responsible for approximately 2000 patients each. During an outpatient visit, for example for a newly diagnosed hypertensive or diabetic, the provider does an assessment and examination, prescribes a regimen and schedules the individual to see the assigned case manager later in the week for an hour teaching appointment. LPNs manage most of the clinic patient flow but do not do exit interviews. Clinical pharmacists, dietitians and a psychologist are also available for specialized teaching appointments. If a patient is scheduled for diagnostic tests, the clerk will alert the case manager who will then call the patient the day before and review preparation instructions. Whenever the patient accesses the system—via admission, the outpatient department, or the nurse phone line—if there is a problem that needs coordination or teaching, the case manager will be notified.

While the case management system promotes continuity of care and good patient education—staff report that their medical center exceeded the national level of 1998 Customer Service Standards for patient education—there is still a need for some immediately accessible patient teaching. Rima Nelson, Director of Primary Care has set up a patient education room with pamphlets and videos adjacent to the clinic so that a veteran newly diagnosed with diabetes can get started right away with teaching rather than waiting for a week until their appointment with the case manager. However, without staff or volunteers to further develop the resources and assist patients access appropriate materials, the room is not yet being used as effectively as it could be. The dilemma highlights the ongoing challenge of balancing the need to provide real-time education in the clinic with the overall resource demands of continuity of care.

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OPT NURSING INTERVIEW TEMPLATE BATTLE CREEK, MICHIGAN VAMC
PLAN /INTERVENTIONS THIS VISIT

Medication/Injections Administered -
Procedures - *Foot exam w/no open areas noted. Pedal pulses strong bilaterally.*

Diagnostic Tests **( ) N/A**
Completed this visit -
Lab results reviewed - HgA1C of 11
Instructions for future tests - FBS prior to next visit

Medications: (X) No Change
Canceled -
Changed -
New -
Side effects and interactions -

( ) Handouts given

Community/social support identified - Attends chronic disease support group at local senior citizen center

Psychosocial/spirituality - Has begun attending church services weekly and reports she feels "at peace" with her life

Interested in Advance Directives?	( )Yes	(X)No
In place?	( ) Yes	(x) No
If yes: Information/forms given?	( ) Yes	( ) No
Referred to Social Work?	( ) Yes	( ) No

Preventive counseling related to:
Diet - *Review of 1200 cal ADA diet and how to comply when eating out*
Weight management - *Discussed need to follow diet and have daily exercise*
Leisure/exercise activities - *Rides her bike one mile/day*
Tobacco use - *Does not use tobacco products*
Alcohol use - *Does not use alcohol*
Seatbelt use - *Reports 100% use*
Home safety/functional status - *She has removed all throw rugs*
PSA risk and benefits education given: ( ) Yes ( ) No (X) N/A
( ) Other (specify)

(x) Telephone Triage
(x) Use explained (x) encouraged (x) number given

EVALUATION

(x) Patient ( ) Significant other understanding of treatment plan:
(x) Comprehensive ( ) Good ( ) Fair ( ) Limited ( ) None

Comments: *Patient is receptive to learning self-management of diabetes*

Collaborative goal (s) to next visit - *Will keep a one week food diary and will measure blood sugar before breakfast and before dinner for this week*

Return visit - *Three months* **Signed by:** *Mary Smith, RN, Primary Care*

Figure 2

PROGRAM NOTES, *from page 5*

Contact:
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Standardizing Patient Education after Health System Integration—Diabetes Education

After the Waco, Temple and Marlin (TX) Medical Centers and the Austin outpatient clinic merged into the Central Texas Veterans Health Care System (CTVHCS), the Patient Education Service was established in 1996 to serve the integrated facility. Given the volume of veterans affected, one of the early priorities of the new service was to standardize and improve the delivery of diabetes education within the system. Staff believed that it was very important for the program content and teacher roles to be consistent from site to site and service to service. For example, veterans reported that staff from different disciplines often repeated content; they were also confused by what they saw as contradictory content such as diet instruction that emphasized carbohydrate counting in one area, the food pyramid in another, and exchange lists in a third.

A first step was for the Patient Education staff to define core information on disease process, nutrition, medication and exercise to be included in the initial five hour workshop. A survey of veterans had determined their preference that the bulk of information be provided in a workshop rather than several short classes. Copies of written program descriptions and handouts that were used by the four clinical services involved in providing diabetes education (Nurse/Diabetes Educator, Nutrition & Food Service, Pharmacy and Physical Medicine and Rehabilitative Service) were also collected. Then each service responsible for a portion of the curriculum was asked to meet (usually via CCTV) and agree upon a content outline, delivery method(s) and handouts.

Patient Education consolidated all of the material into one program outline and one set of handouts for the system. An electronic documentation template was also designed. Folders of print materials were prepared centrally which assured some degree of uniformity. The initial pilot test of the consolidated program, however, showed that staff tended to teach as they always had with overlapping content and non adherence to agreed-upon outlines. Veteran feedback documented that staff continued to repeat each other.

Additional interdisciplinary meetings encouraged all instructors to see how their parts fit the whole. To strengthen the educational effort many teachers in the program were sent for additional education about diabetes. Three more staff were certified as diabetes educators - bringing the total number of CDE's in the system to six.

A survival skills booklet was also developed to bridge the gap between diagnosis and the diabetes workshop. A substantial number of veterans coming in for tests received a diagnosis of diabetes but had to return for the initial workshop at a later date. This brief handout provides basic content about the disease and diabetes diets meant to answer a very short-term need for information. Inservices were held at each site to encourage appropriate use of the booklet. Follow-up classes to supplement the basic five hour workshop are also under development. Two special nutrition classes—Food Exchanges and Recipe Adjustment are already offered system wide; two others—Stress Management and Dental Management—will be available soon.

In the mean time, one Certified Diabetes Educator prepared her part of the workshop as a Power Point presentation. She found that this approach helped focus the group, and keep her "on track" and within her allotted time. With a small electronic device, the computerized presentation is shown on the big screen TV in the classroom. When patients gave the technology and the content favorable reviews, the rest of the workshop outline was put in Power Point format and staff at two sites began using it. Both patients and staff reported high satisfaction.

Building on this positive feedback, central Patient Education Service adopted the printed Power Point presentations as the core of the Diabetes Education Workbook designed to replace the labor-intensive folder of handouts. The workbooks are now used at all sites, which have expanded to include two com-

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munity based outpatient clinics and will soon include two more. Administration has promised lap tops to facilitate using the Power Point presentation at all sites as well.

Integration of the teaching programs went more slowly than expected because of logistic difficulties of working with multiple sites and the natural inclination to defend one's turf during periods of change. However, the continued emphasis on communication and feedback from veterans and the primary need of professionals to provide quality care encouraged all staff involved to try new behaviors.

Contact Nancy McKinney, RN, CDE, Patient Educator, Waco site, CTVHCS, COM 254/752-6581, Ext. 6933; FTS 700/734-6933.

NEW Feature: Performance Improvement Training

Every quarter, Patient Education in Primary Care will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit choose one of the following two options:
Read the entire October 1999 newsletter and provide brief answers to the following questions. Turn these in to your supervisor along with a copy of the newsletter OR
Organize a one hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter—and discuss the following questions. Turn in a master list of journal club participants along with a copy of the newsletter.

QUESTIONS:
1. What ideas do you have for helping your organization prepare for the patient education component of your next JCAHO survey?
2 How well do you think your patients' questions are answered before they leave the primary care clinic? Are there changes that are needed?
3. Are there inconsistencies/duplications in patient education programs across sites or disciplines that reduce the effectiveness of the teaching? If yes, how could this be improved?

— COMING IN JANUARY —
Risk Assessment and Teaching about Hepatitis C

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES.

Do you have any successful patient education strategies that you would like to share with us?

Contact Barbara Giloth (773/743-8206 or email bgilot1@uic.edu), Carol Maller (700/572-2400, ext 4656 or email maller.carol@albuquerque.va.gov) or Charlene Stokamer (700/662-4218 or email stokamer.charlene@new-york.va.gov) with your input!

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